TRICARE Data Quality Course

Current & Future Prospective Payment System

The Quadruple Aim: Working Together, Achieving Success

Program Review and Evaluation

September 2012

OSD(Health Affairs); Health Budgets & Financial Policy

Resourcing the Direct Care System for Value

The Direct Care System (DCS) is the heart of military medicine and provides:

- a ready to deploy medical capability
- a medically ready force
- delivery of the health benefit to warriors and their families

..but at the appropriate value?

$$\frac{\text{Outputs (Activities)} + \text{Outcomes (Readiness, Population Health)} + \text{Customer satisfaction}}{\text{Resources (MilPers, appropriations, reimbursements)}}$$

Creating Breakthrough Performance in the MHS

Each Element is essential.

Agenda

- Current Prospective Payment System
- Future Prospective Payment System??
  - Performance Based Planning Pilots
- Issues to consider for Data Quality

Background

- PPS initiated in 2005 to rationalize the direct care budget adjustments
  - Provide funds for recapture
  - Budget to follow performance
- Initially proposed as a capitated system
  - Considered too risky and too large a leap
    - Fee for service (FFS) system seen as simpler to implement and necessary to familiarize the staff with workload measures
  - SMMAC decided to start as a Fee for Service system with capitation some time in the future

PPS Value of Care

- Value of MTF Workload
  - Fee for Service rate for workload produced
- Rates based on price at which care can be purchased
  - TMAC rates
  - Not MTF costs
- Computed at MTF level but allocated to services
  - Rolled up to Services

TMAC versus PPS

Civilian

- Inpatient
  - Institutional
    - Hospital (MS-DRG)
      - Including ancillaries, pharmacy
  - Professional (RVU)
    - Surgeon
    - Anesthesiologist
    - Rounds
    - Consultants
- Outpatient
  - Professional (RVU)
  - Institutional (APC)
- Outpatient Ancillary
  - (RVU/Fee Schedule)

Direct Care PPS

- Inpatient (RWP, i.e. MS-DRG)
  - All Institutional and Professional
    - Hospital
      - Including ancillaries, pharmacy
    - Surgeon
    - Anesthesiologist
    - Internist
    - Consultants
- Outpatient
  - Professional (RVU)
  - Institutional (APC)
    - Emergency Room and Same Day Surgery
- Outpatient Ancillary (Pass Thru)
  - None

FY 12 Changes in RVU

- Provider Affected (PA) Changes:
  - Nurse Crediting (no credit for procedures Skill Type 3 and 4 cannot perform; e.g., Physician E&M codes, Shunt procedures, etc.)
  - Multiple Provider Discounting (1st and 2nd provider are always credited, although sometimes the 2nd is only at 20%, 3rd provider never credited)
  - Multiple procedure discounting
  - Modifier impact (e.g., increase for bilaterals; decrease for procedure stopped before completion)
    - SADR used 1st modifier; CAPER uses both
  - Procedure clean-up (e.g., brain lesion on a telcon, credit for the telcon not the brain lesion; same for follow-up, credit for the follow-up not the procedure; E&M and procedure, E&M only counted if mod 25 is used)

FY12 Changes in RVU

- CAPER: no credit for (SADR got credit)
  - ✓ J - Rx administered in doctor's office, Rx already pays for it
  - ✓ K - orthotics, lab already paid for elsewhere
  - ✓ L - splints, shoe inserts, etc., already paid for elsewhere

Facility / Non-Facility Flag

- Indicates whether the care was provided in a facility or non-facility setting
  - F = Facility (MEPRS A, MEPRS BIA, MEPRS B**5/7, 0124 B**6, specific CPT (cardiac cath, etc)
  - N = Non-Facility (all others)
  - R = Resource Sharing, VA
- Uses: computation of Practice Expense RVU, PPS

Valuing MHS Workload Fee for Service Rates FY12

- Value per MS-RWP - $8,688 (MEPRS A codes)
  - Average amount allowed
    - Including institutional and professional fees
    - Excluding Mental Health (MH)/Substance Abuse (SA)
    - Adjusted for local Wage index and Indirect Medical Education Adjustment
- Value per Mental Health Bed Day - $803 (MEPRS A codes)
  - Average amount allowed
    - Including institutional and professional fees
    - Adjusted for local Wage index and Indirect Medical Education Adjustment
- Value per RVU - $33.97 (MEPRS B codes)
  - Standard Rate – like TMAC/CMS
    - Excluding Ancillary, Home Health, Facility Charges
    - Adjusted for local geographic price index both Work and Practice
- Value per APC - $69.61 (Facility records)
  - Standard Rate

PPS Impact

- While calculations in PPS are done at the MTF level, HA/TMA adjustments are just to the Services
  - Each Service has its own methodology for allocating to the MTFs
    - Some aspects of PPS are involved in these methodologies
- Most medical personnel are now familiar with workload measurement (RVUs, RWPs)

Issue

- Has FFS PPS outlived its usefulness?
  - Concern that FFS induces:
    - Over-utilization
    - Upcoding
    - Treatment over prevention
  - Considerable discussion each year on mid-year adjustments
    - Competition/rancor between services
  - MTFs strong focus only on PPS earning areas

Future Prospective Payment System??

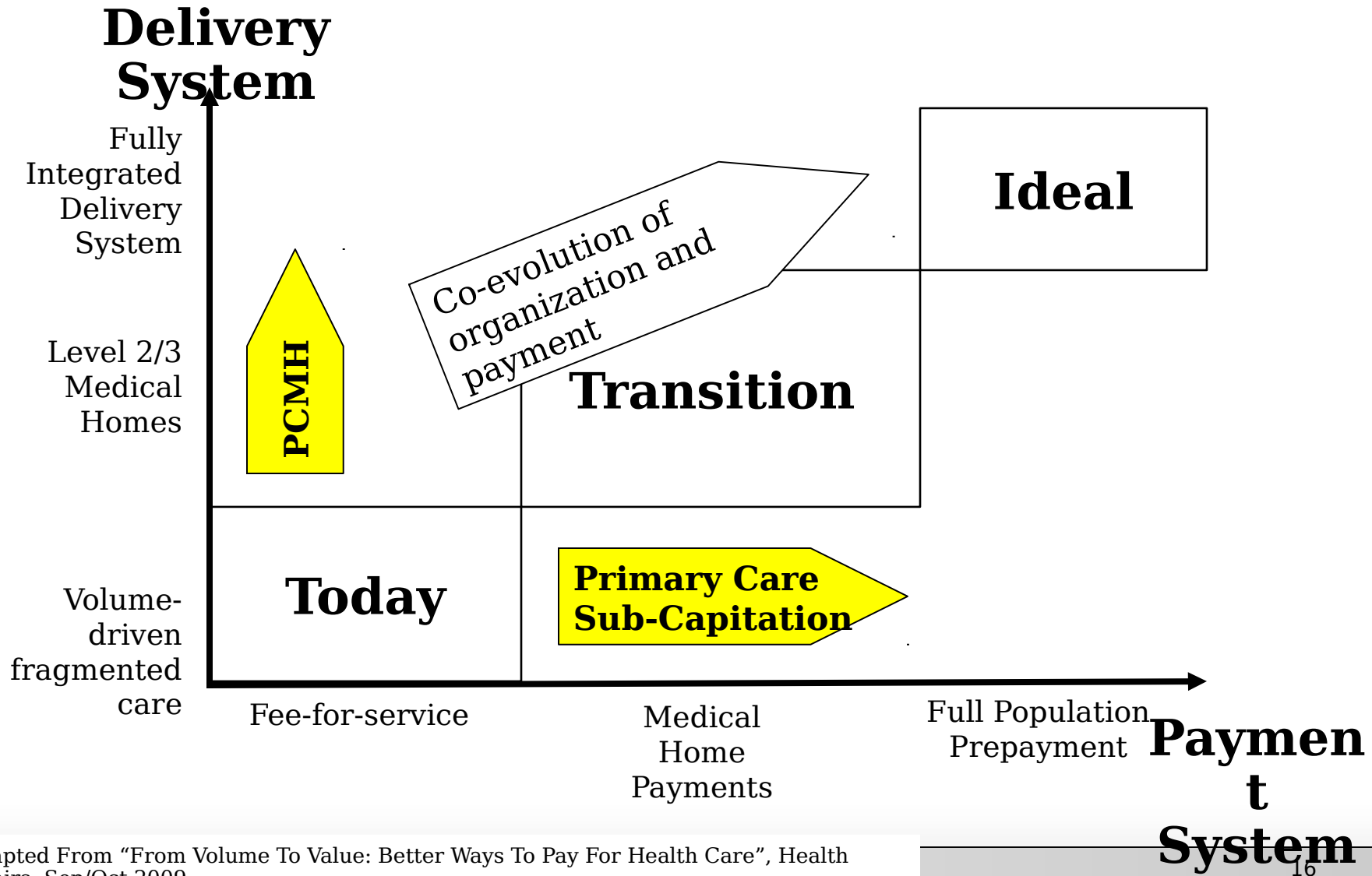
Performance-Based Planning

Expanding Pay for Performance to Match the Vision

- Premise: MHS Value is predicated on three elements
  - Outputs - the volume of work that we accomplish, measured currently by RVUs/APCs and RWPs/Bed Days
    - Incomplete
  - Outcomes – often measured via factors such as HEDIS/JCAHO
  - Customer Satisfaction
- Our focus to date has been centered on productivity (Outputs) as the MHS source of value for the Department.

- Goal: Create a financial mechanism for the direct care system that will emphasize value measures for outcomes and customer satisfaction in a balanced fashion with outputs

Transition In Both Payment & Delivery Systems



Adapted From "From Volume To Value: Better Ways To Pay For Health Care", Health Affairs, Sep/Oct 2009.

Expanding Pay for Performance to Match the MHS Vision

$$\frac{\text{Volume (Activities, Episodes, Population)} + \text{Outcomes (Readiness, Population Health, Customer satisfaction)}}{\text{Resources (MilPers, appropriations, reimbursements)}}$$

How Much?
How Well?
At What Cost?

How Much?

Mechanism	Units	Coverage	Potential Unintended Side Effect
Fee for Service	Procedures, MS-DRGs, Bed days	Encounter	Churning Up-coding Treatment over Prevention
Episode	Procedure plus associated care		Churning Up-coding Treatment over Prevention
Care Management Fee	Population		No value added
Sub-Capitation	Population	All Primary Care	Shift to specialty care Denied access
Capitation	Population	All Care	Denied access Under utilization

- Answering “How much” is not enough.
  - Unintended side effects can reduce value.

How Well?

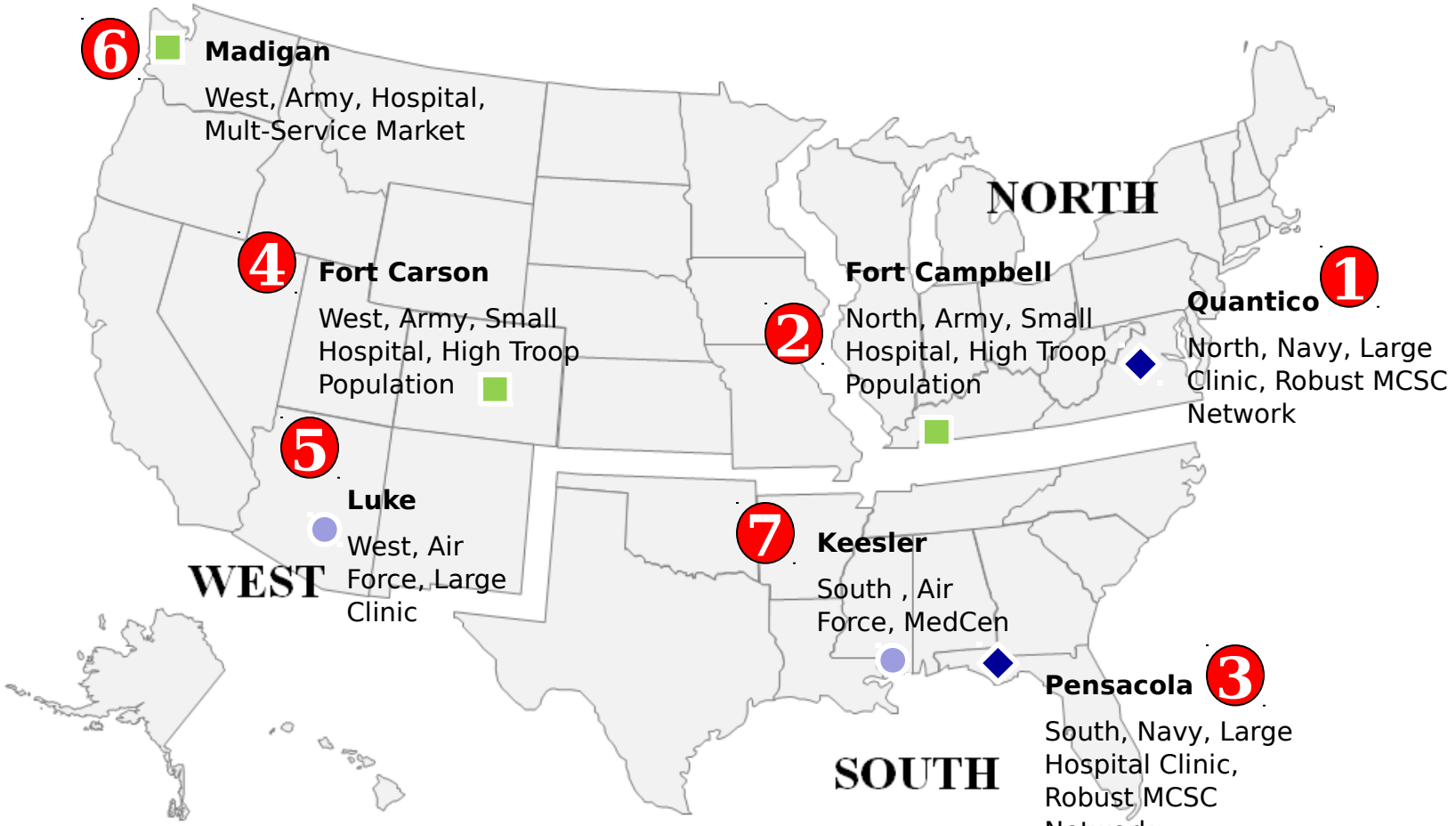
	Measure
Prevention	HEDIS Preventive Services
Access	3rd Next Available
Treatment	ORYX
Continuity	% of visits seeing own PCM
Outcomes	HEDIS Outcome Measures Never Events Mortality Quality Adjusted Life Years (QALYs)
Satisfaction	Visit Satisfaction Plan Satisfaction
Cost	Productivity/efficiency ER Utilization PMPM

- "How Well" combined with "How Much"
  - Allows Pay for Performance to match MHS Vision

Performance Planning Integrated Project Team

- The Joint Health Operations Council (JHOC) chartered a Performance Planning Integrated Project Team (IPT)
  - Create a revised incentive structure and planning approach aligned with the Quadruple Aim
    - Readiness/Population Health/Experience of Care/Per Capita Cost
  - The approach encompasses the total beneficiary population
    - Direct and Purchased
    - Prime, Standard
  - Piloted at seven sites in 2010.

Pilot Sites


6
Madigan
West, Army, Hospital, Mult-Service Market
NORTH
4
Fort Carson
West, Army, Small Hospital, High Troop Population
2
Fort Campbell
North, Army, Small Hospital, High Troop Population
1
Quantico
North, Navy, Large Clinic, Robust MCSC Network
5
Luke
West, Air Force, Large Clinic
WEST
7
Keesler
South , Air Force, MedCen
3
Pensacola
South, Navy, Large Hospital Clinic, Robust MCSC Network
SOUTH
Army
Navy
Air Force

How to Succeed

- Current Prospective Payment System (fee for service)
  - Maximize workload
    - Recapture private sector care
    - Optimize coding
    - Complete records
    - Improve productivity
    - Maximize patient visits
    - Fee for Service rate for workload produced
- Pilots – Follow Quadruple Aim
  - Readiness (TBD)
  - Experience of care
  - Population Health
  - Per Capita Cost

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- Pilots – Follow Quadruple Aim
  - Readiness (TBD)
  - Experience of care
  - Population Health
  - Per Capita Cost

How to Succeed, cont

- Experience of Care
  - Satisfied customer
  - Timely access
  - PCMs treat own patients
  - Follow clinical guidelines
- Population Health
  - Follow preventive screening protocols

How to Succeed, cont

- Per capita cost
  - Effective management of enrollees
    - Manage utilization
    - Provide care at appropriate location
      - Minimize ER use
  - Effective use of MTF & staff
    - Increase productivity
    - Recapture private sector care
  - Effective management of PCMH enrollees
    - Use of non-visit touches
    - Efficient use of support staff
    - Optimize enrollment ratios
    - Comprehensive care coordination

PMPM & ER

Productivity (RVUs, RWPs & APGs)

PCMH & Capitation

FY 11 Performance Planning Site Results

	Madigan	Carson	Campbell	Pensacola	Quantico	Keesler	Luke	Total
Measure								
HEDIS	1,241,385	766,130	655,038	198,465	18,535	410,630	73,568	3,363,750
ORYX	3,600	6,400	39,067	1,067	-	8,400	-	58,533
Satisfaction	45,853	23,918	947	217,245	140,037	5,293	11,643	444,936
Continuity	317,475	(103,308)	(669,354)	76,620	(256,518)	(296,403)	(57,495)	(988,983)
Access	(360,456)	224,161	(526,867)	(179,494)	(187,297)	33,775	(238,878)	(1,235,055)
ER Rate	38,822	44,255	(124,499)	(30,535)	(10,820)	6,229	(11,098)	(87,645)
Workload	(2,883,587)	22,236,590	827,262	(75,277)	1,455,457	7,981,994	2,117,533	31,659,972
PMPM	(4,687,038)	(784,784)	(9,056,840)	-	(668,717)	995,769	235,425	(13,966,185)
Care Management	2,995,705	1,864,985	1,973,943	1,308,735	698,380	686,353	794,238	10,322,338
Total	(3,288,240)	24,278,346	(6,881,303)	1,516,826	1,189,058	9,832,039	2,924,936	29,571,661
Balance	-	102,088	-	31,842	-	92,502	16,148	242,580
Adjustment	(3,288,240)	24,380,434	(6,881,303)	1,548,668	1,189,058	9,924,541	2,941,084	29,814,242
Hold Harmless	(2,883,587)	24,380,434	827,262	1,548,668	1,455,457	9,924,541	2,941,084	38,193,859

Observations:

- HEDIS and Workload are for the most part positive reflecting previous incentives.
- Satisfaction generally positive.
- Continuity and access results are mixed.
- PMPM for the most part is negative reflecting higher than targeted per capita costs.

FY 11 Performance Planning Pilots

- Service Level adjustments
- Difference between Standard PPS earning and Performance adjustments
  - Included Hold Harmless
  - Numbers would be lower for two Services if hold harmless provision was not in effect

	Army	Navy	Air Force
Standard PPS Earnings	$ 20,180,265	$ 1,380,180	$ 10,099,528
Performance Planning Earnings	$ 21,947,156	$ 2,836,095	$ 12,748,303
	$ 1,766,891	$ 1,455,916	$ 2,648,775
Difference	$ 1,766,891	$ 1,455,915	$ 2,648,775
If no hold harmless Provision	(6,341,254)	1,183,766	2,648,775

Pilot Performance for FY12

The following is a summary of decisions that have been made for FY12 regarding the Pilots:

- The original 7 pilot sites will be maintained for FY12
- Army will use PBAM (Performance Based Adjustment Model)
- Air Force will use MHPI (Medical Home Performance Index)
- Navy will use the FY12 Performance Planning Pilot including primary care sub-capitation

- Post year Evaluation will be based on both improvement over baseline and performance against standards
  - Provide some insights for possible changes in Pay for Performance within the MHS

Navy Pilot Performance Funding Items

- How Much?
  - Care Management Fee
  - Primary Care Sub-capitation
  - Traditional FFS for care outside of Sub-Capitation

- How Well?
  - HEDIS Quality adjustment
    - Colorectal/Cervical/Mammogram/Diabetes
  - Access/Continuity of care adjustment
    - 3rd Available Appointment
    - Continuity of Care
  - Satisfaction
    - Not available, due to change in Survey instrument
  - ER Utilization adjustment
  - PMPM adjustment

Balanced Bonus Eligible Items

FY12 PPS Mid-Year Summary for Services

Adjusted Army Profile	Army	Navy	Air Force	JTF (1)	MHS Total
PPS Recon with SA	$ 2,911,345	$ 9,488,684	$ 11,638,532	$ (65,582,389)	
Adjustments to Base Recon Value					
PPS Funding Increase	$ (48,753,000)	$ -	$ -	$ -	
HEDIS	$ 13,169,826	$ 9,421,293	$ 5,829,329	$ 3,195,043	
Pilot site funds (2)	$ 17,740,504	$ 278,709	$ 8,682,316	$ -	
Adjustment for prior year	$ 11,657,780				
Recon + Adjustments Total	**$ (3,273,545)**	**$ 19,188,686**	**$ 26,150,177**	**$ 3,195,043**	**$ 45,260,362**

(1) JTF Removed from Reconciliation until 2014 per decision from CFOIC.
Currently there is no O&M factor for JTF (Service O&M factors range from 35% to 68%)
(2) Per decision from CFOIC, Keesler is not to use a FY09 baseline.
Currently Keesler is using a Rolling 12 to Prior Rolling 12 for increases.

Pilot Evaluation Criteria

- The quantitative evaluation component will look to answer four questions:
  - Do the experimental sites improve more than the control sites?
  - Do the experimental sites perform better than the control sites?
  - Do the experimental sites in one service improve more than the experimental sites in the other Services?
  - Do the experimental sites in one Service perform better than the experimental sites in the other Services?

- Quantitative Evaluation Components:
  - Performance
    1-5 point scale for performance above the 50th percentile on each measure
  - Improvement
    1-5 point scale for improvement in closing the gap with target more than 10%

- Is there a need to develop a lessons learned component to the evaluation?

- To isolate the effects of PCMH from the Service specific incentive plans data required at 4th Level MEPRS Code

Performance and Management Measures

FY12 MTF Performance Pilot evaluation measures are in bold

Readiness	Population Health
• **% of Active-Duty Personnel Health Assessments (PHA) Completed** • Medical Readiness Indeterminate Rate • Medically Ready to Deploy • Active Duty Obesity (BMI >=30) • Active Duty PTSD Prevalence • Active Duty Depression Prevalence • Medical Board Timeliness	• **Mammography Screening** • **Colorectal Screening** • **Cervical Screening** • Depression Prevalence • Obesity Documentation – Adult • Obesity Documentation – Adolescent/Child • Tobacco Usage • Exclusive Breastfeeding During Hospitalization • **Well Child Visits**
Experience of Care	**Per Capita Cost**
• **Satisfaction with Visit (Primary Care/Specialty Care)** • Satisfaction with Getting Timely Care Rate • **% of visits where MTF enrollees see their PCM** • **Primary Care 3rd Available (Acute/Routine)** • Readmission Rate • PN-antibiotic received • **Diabetes A1c Screening** • **Diabetes LDL < 100 mg/dL** • **Diabetes A1c >9** • **Cholesterol Management LDL Screening** • **Cholesterol Management LDL Control** • Antidepressant Medical Management Acute Phase • Antidepressant Medical Management Continuous Phase • **Mental Health Follow-Up 7 days** • **Mental Health Follow-Up 30 days**	• **PMPM** • Enrollee Utilization o Bed Days per 1,000 (direct/network) o RVUs per 100 (Direct/Network) • OR Utilization • **ER visits per 100 (Direct/Network)** • **Cost per MS¹-RWP (In Progress, exploring the feasibility of pulling out MH MDC 19/20** • **Cost per Super RVU (APC² + RVU) exploring the feasibility of pulling out primary care & specialty care** • **Total Super RVU's per enrollee per year** • Inpatient Cost per RWP • Outpatient Cost per RWP • Average Daily Patient Load • % Specialty Care for non-enrollees • % Inpatient Care for non-enrollees • % of home delivery (pharmacy) • % of generics used (pharmacy)
Demographics	**Other**
• Enrollment (PCMH / Other Prime) • Eligible Population • PCMH Teams • Enrollment Per Team, PCMH PCM, Other PCM	• TBD

Performance Pilot Scores FY2012

DMIS	Name	Performance Points	Improvement Points
Army			
0125	MADIGAN AMC-FT. LEWIS	1.29	1.25
0052	TRIPLER AMC-FT SHAFTER	1.32	1.33
0032	EVANS ACH-FT. CARSON	1.55	1.92
0049	WINN ACH-FT. STEWART	1.03	1.17
0060	BLANCHFIELD ACH-FT. CAMPBELL	1.63	1.42
0048	MARTIN ACH-FT. BENNING	1.13	1.23
Air Force			
0009	56th MED GRP-LUKE	1.16	1.25
0066	779th MED GRP-ANDREWS	0.66	1.14
0073	81st MED GRP-KEESLER	0.88	1.30
0006	673rd MED GRP-ELMENDORF	0.90	0.82
Navy			
0038	NH PENSACOLA	1.06	1.44
0039	NH JACKSONVILLE	0.91	1.24
0385	NHC QUANTICO	0.95	0.68
0103	NAVAL HEALTH CLINIC CHARLESTON	2.05	2.47

Sites alternate, with First facility being the Pilot, and Second Facility the Comparison Site
Maximum score possible is 3.5, since Readiness measure is not available

Issues to Consider

- All MTFs need to Ensure Timely data submission
- Professional Services
  - Professional services should be coded for Inpatient
  - Accurate coding
    - Ensure proper coding for care including Units of Service
    - Need to ensure coding matches documentation
    - Eventually audit adjustments to claims
- Treatment of Enrollees
  - Quality payments will rely on accurate identification of Enrollees
  - Documentation of treatment for Preventive Services
- Workload Trending
  - CMS changes to weights can cause misleading trends
    - Budget Neutrality Factor used for CY06 and earlier
  - CY10 removal of weights for Consult codes
    - CMS stopped paying, but increased E&M codes
    - MHS zero weight for consult codes in CY11
  - CY11 significant increase in Practice Expense RVUs
    - CMS Conversion factor decreases by over 10%

Back-up

BACK UP SLIDES

IME Factors

DMIS	Name	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY11	FY12
0014	DAVID GRANT	1.4141	1.3765	1.5737	**1.5996**	**1.6313**	**1.5676**	**1.4778**	**1.3485**	**1.2930**	1.2155	1.1664
0024	PENDLETON	1.2895	1.1860	1.1681	**1.1848**	**1.1828**	**1.1739**	**1.1446**	**1.1304**	**1.1476**	1.1256	1.1185
0029	SAN DIEGO	1.6415	1.5067	1.5067	**1.5173**	**1.4929**	**1.4588**	**1.4339**	**1.4554**	**1.5370**	1.5226	1.5483
0037	WALTER REED	1.5849	1.5175	1.5265	**1.5523**	**1.5368**	**1.5824**	**1.5351**	**1.5061**	**1.6961**	1.7415	1.5868
0038	PENSACOLA	1.2692	1.2269	1.2269	**1.2302**	**1.1938**	**1.1713**	**1.1972**	**1.2092**	**1.2045**	1.1894	1.1897
0039	JACKSONVILLE	1.3484	1.2954	1.2911	**1.2944**	**1.2866**	**1.2669**	**1.2437**	**1.2690**	**1.2086**	1.3290	1.2206
0042	EGLIN	1.2544	1.2801	1.3120	**1.3202**	**1.2622**	**1.1859**	**1.2012**	**1.1928**	**1.2346**	1.2346	1.2124
0047	EISENHOWER	1.2772	1.2216	1.2208	**1.2318**	**1.2096**	**1.2352**	**1.2585**	**1.2031**	**1.2249**	1.2746	1.2546
0048	MARTIN	1.2230	1.1733	1.1462	**1.1547**	**1.1477**	**1.1422**	**1.1451**	**1.1408**	**1.1498**	1.1519	1.1465
0052	TRIPLER	1.3792	1.3249	1.3319	**1.3482**	**1.3987**	**1.3813**	**1.4477**	**1.4400**	**1.4859**	1.4607	1.4142
0055	SCOTT	1.3377	1.2983	1.3119	**1.3034**	**1.2689**	**1.2554**	**1.0000**	**1.0000**	**1.0000**	1.0000	1.0000
0066	MALCOLM GROW	1.3646	1.3306	1.3898	**1.4492**	**1.4366**	**1.4199**	**1.4334**	**1.3663**	**1.2949**	1.0000	1.0000
0067	BETHESDA	1.6914	1.5430	1.5413	**1.4705**	**1.4139**	**1.3984**	**1.3598**	**1.3493**	**1.3882**	1.3384	1.5868
0073	KEESLER	1.4844	1.3613	1.2533	**1.4352**	**1.4806**	**1.0000**	**1.0000**	**1.0737**	**1.0737**	1.1410	1.1730
0078	EHRLING BERGQUIST	1.3313	1.3286	1.3961	**1.5929**	**1.3220**	**1.0000**	**1.0000**	**1.0000**	**1.0000**	1.0000	1.0000
0086	KELLER	1.0114	1.0309	1.0417	**1.0398**	**1.0394**	**1.0372**	**1.0379**	**1.0379**	**1.0394**	1.0394	1.0437
0089	WOMACK	1.1396	1.1176	1.1254	**1.1259**	**1.1187**	**1.1460**	**1.1524**	**1.1425**	**1.1471**	1.1277	1.1103
0091	LEJEUNE	1.0000	1.0000	1.0000	**1.0621**	**1.0604**	**1.0976**	**1.0637**	**1.0637**	**1.0548**	1.0557	1.0615
0095	WRIGHT-PATTERSON	1.6438	1.6523	1.7406	**1.6789**	**1.6153**	**1.5976**	**1.5004**	**1.3764**	**1.4453**	1.4453	1.4493
0108	WILLIAM BEAUMONT	1.2425	1.1995	1.1971	**1.2033**	**1.2267**	**1.2041**	**1.2203**	**1.2129**	**1.2461**	1.2665	1.2725
0109	BROOKE	1.5289	1.4459	1.4553	**1.4776**	**1.4565**	**1.4353**	**1.3961**	**1.4474**	**1.5329**	1.4864	1.5569
0110	DARNALL	1.1182	1.0996	1.0996	**1.1035**	**1.0977**	**1.0914**	**1.0992**	**1.0987**	**1.0932**	1.0932	1.0934
0117	WILFORD HALL	1.5818	1.4904	1.6006	**1.6300**	**1.5887**	**1.5694**	**1.5646**	**1.5887**	**1.6467**	1.6562	1.0000
0123	DEWITT	1.2275	1.1883	1.1883	**1.1942**	**1.1920**	**1.2071**	**1.2381**	**1.1974**	**1.2011**	1.2062	1.0861
0124	PORTSMOUTH	1.3389	1.3066	1.3066	**1.3216**	**1.3126**	**1.3005**	**1.2749**	**1.2684**	**1.3324**	1.3334	1.3464
0125	MADIGAN	1.6389	1.5363	1.5630	**1.5438**	**1.4788**	**1.4499**	**1.4145**	**1.4534**	**1.4947**	1.4698	1.4814
0126	BREMERTON	1.1716	1.1701	1.1817	**1.1902**	**1.2009**	**1.1977**	**1.1692**	**1.1858**	**1.1783**	1.1873	1.1841

Value of 1.0 is used if there is no IME to zero out calculation.

Primary Care Capitation

- Determine historical Primary Care Capitation Rate
  - Apply appropriate logic for MHS workload
    - To include
      - Code Sets
      - Clinic/Provider restrictions
  - Ensure that rate includes all care for enrollees
    - Direct Same MTF/Direct Other MTF/Purchased Care
  - Divide total workload (DC/PSC) by enrollees to get historical PC capitation rate (utilization rate) at that MTF
- In evaluation year, for MHP enrollees
  - Ignore actual primary care workload for MHP enrollees
  - Substitute historical utilization rate after subtracting PSC utilization for MHP enrollees
- Effect: If utilization is contained, MTF will still get workload credit as if utilization stayed elevated
  - If workload can be recaptured from PSC, MTF workload credit could increase with no actual increase in workload

HEDIS Preventive Services

- Adherence to HEDIS Guidelines
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Colorectal Screening
  - Diabetes A1c Screen
  - Asthma Meds
  - Diabetes A1c<9
  - Diabetes LDL<100

DRG Comparison

- Historical DRG
  - System to classify hospital cases into one of approximately 500 groups
  - System in use since approximately 1983, with minor updates on a yearly basis
  - Calculated for TRICARE using CMS method just for our beneficiaries with-in Purchased Care claims

- MS-DRG – Severity Adjusted DRGs
  - System used to differentiate levels of complexity for the DRGs
  - Approximately 750 different groups
  - CMS implemented in 2008
  - TRICARE implemented in 2009

RVU comparison

- Old Method
  - Uses Work RVU for all payments
    - Work RVU only represents provider portion
  - Payments based on Product Lines
    - Defined by MEPRS codes
    - Significant variation in rates ($38/RVU to $330/RVU)
    - Rates based on Allowed Amount from Purchased Care claims divided by Work RVUs
- New Total RVU method
  - Uses both Work and Practice RVUs for payments
    - Practice RVU represents the cost of the staff/office/equipment
    - Includes Units of Service adjustments for both RVUs
  - Provides appropriate credit for equipment intensive procedures
  - Allows for a Standard Rate per RVU
    - Can use same rate as Purchase Care
  - Used with Ambulatory Payment Classification (APCs)
    - Facility charges now available for ER and Same Day Surgery
    - Consistent with TRICARE change for CY09

Geographic Practice Cost Index (GPCI)

- Based on Medicare locality Adjustments
- Different rates for Work and Non-Facility Practice
  - Work
    - Generally 1.0 +, max 1.5 for Alaska
  - Non-Facility Practice
    - Range 0.803 (part of Missouri) to 1.342 (part of California)
- Payment Amount
  - Multiply the RVU for each component times the GPCI for that component

Expansion of PPS for External Workload

- Valuation to began in FY2008
  - All reporting will be considered “new” workload
  - Standardized reporting method across Services
- External Partnerships (5400) and VA facilities (2000)
  - Differentiate Professional Service vs Facility Charges
- Payment based on Total RVU
  - Enhanced (Work + Facility Practice)
  - Standard Rate similar to CMS
    - Not Product Line specific – FY10 same as all RVUs
  - Professional Providers only
  - MEPRS A & B codes only
- Still must solve DoD Circuit Rider workload reporting

Current PPS Workload

- Inpatient – MEPRS A Workcenters
  - Non-Mental Health – Severity Adjusted DRGs Relative Weighted Products (MS-RWPs)
  - Mental Health - Bed Days
- Outpatient – MEPRS B Workcenters
  - Provider Aggregate Enhanced Work + Practice Relative Value Units (RVUs)
    - Excluding Generic Providers
  - Ambulatory Payment Classification (APCs)
    - Facility charges now available for Emergency Room (ER) and Same Day Surgery (SDS)
    - Consistent with TRICARE change for CY09

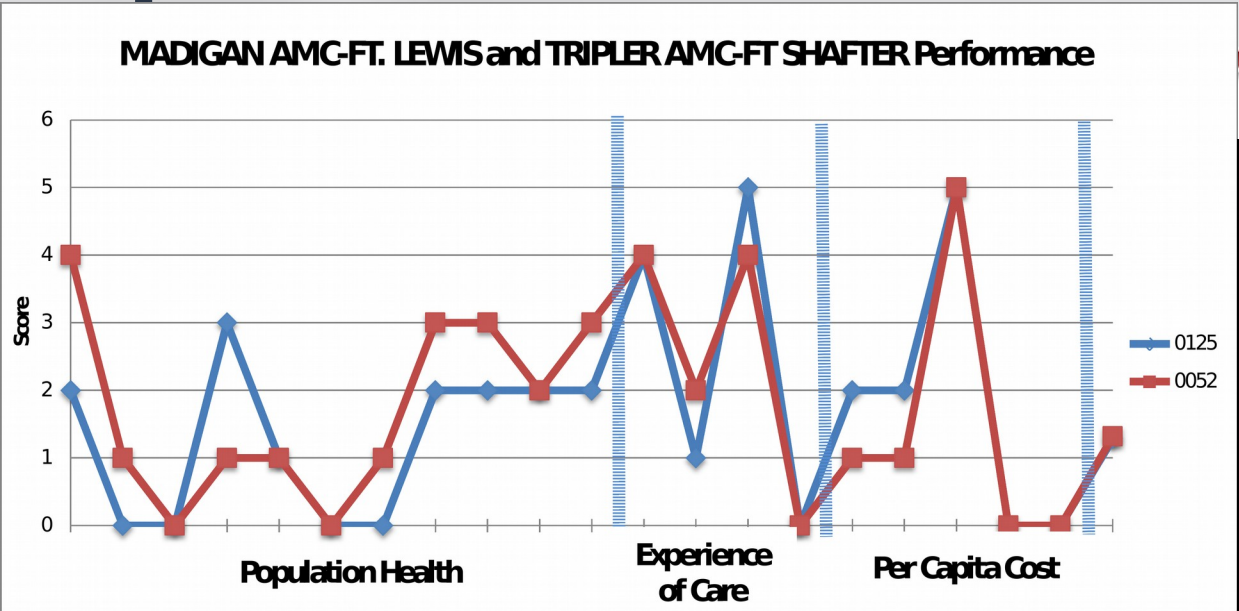
Weight Changes Adjustments

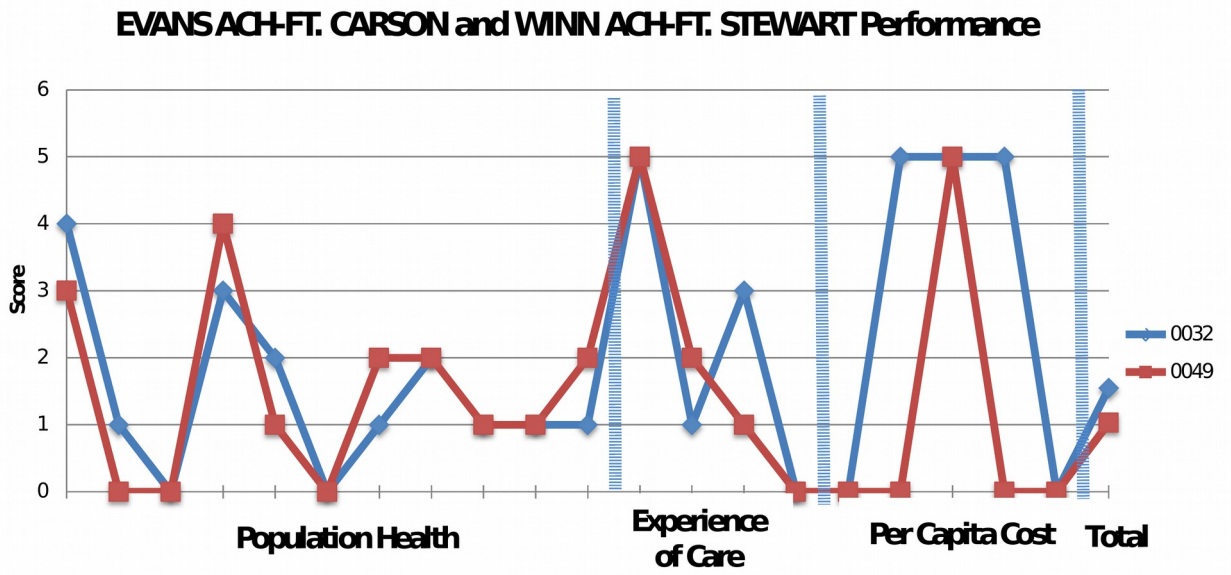
- Previous adjustments for weight/coding changes between CY09/10
  - Overall adjustment for weight changes
- Service Specific adjustment for Consult codes not being Budget Neutral in Direct Care
  - Affects FY10 and out, compared to FY09
- CY11 Significant change in Practice Expense RVUs
  - Caused Conversion factor to decrease by almost 10%

GWOT Workload

- Already paid for under OCO funding
  - Significant workload changes pre/post deployment not part of traditional health care benefit delivery
  - Exaggerates workload reporting changes
  - Removed in years prior to last year
- Remove GWOT workload from workload accounting based on Diagnostic codes
  - V70.5_4 Pre-Deployment Related encounter
  - V70.5_5 Intra-Deployment encounter
  - V70.5_6 Post-deployment related encounter
  - V70.5_D Pre-Deployment Assessment
  - V70.5_E Initial Post-Deployment Assessment
  - V70.5_F Post Deployment Health Reassessment (PDHRA)
  - V70.5_G Global War on Terrorism (GWOT)
- Can be accounted for in Re-Baseline

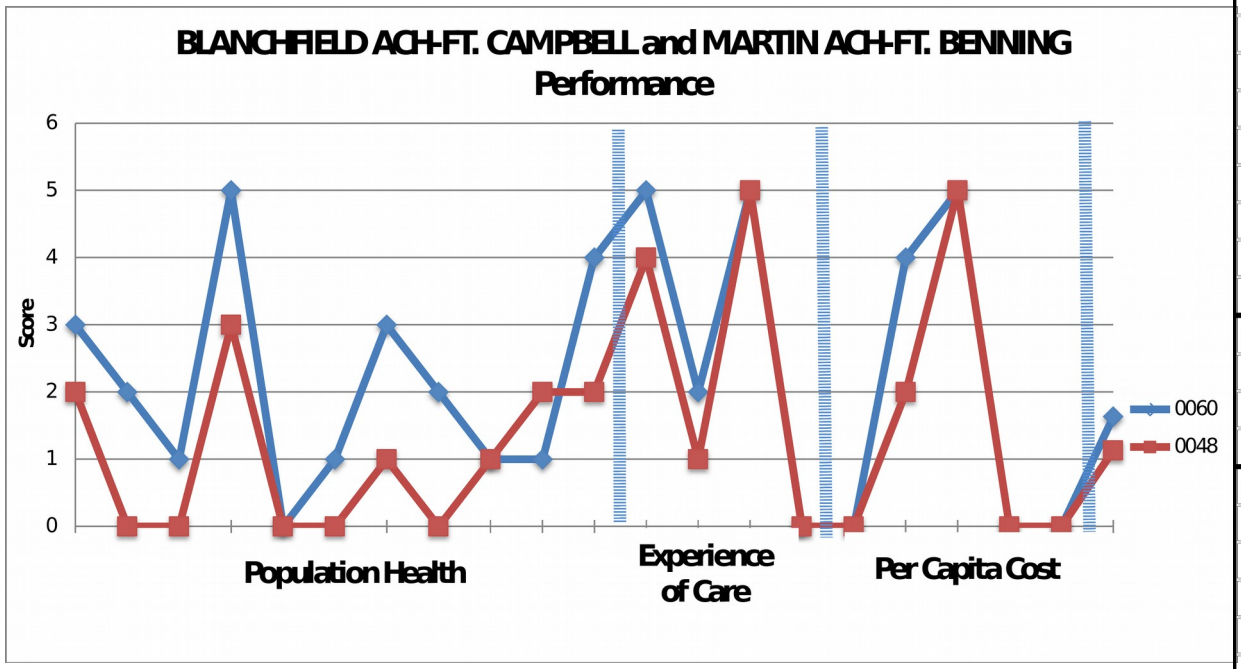
Army Site Performance Slide 1





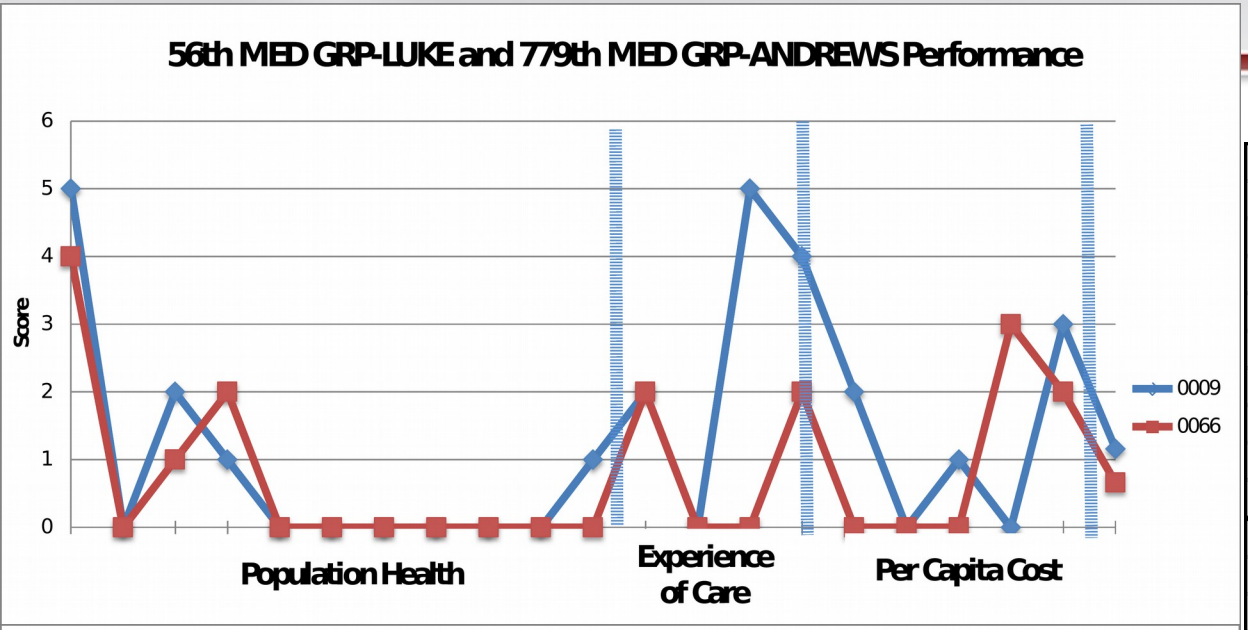
Population Health – 20%	%Vst w/ PCM
	3rd Avail Acute
	3rd Avail Routine
	Diabetes A1c Screen
	Diabetes LDL <100 MG/dL
	Diabetes A1c >9
	Cholesterol Mgmt LDL Screen
	Cholesterol Mgmt LDL Control
	MH Follow-up 7 days
	MH Follow-up 30 days
Experience of Care – 20%	Mammogram Screening
	Colorectal Screening
	Cervical Screening
	Well Child Visits
Per Capita Cost – 30%	PMPM
	ER Vst/100
	Cost per MS-RWP
	Cost per Super RVU
	MS-RWP / 1000 Eq Lv
	SRVU / Eq Lv
Total Score	

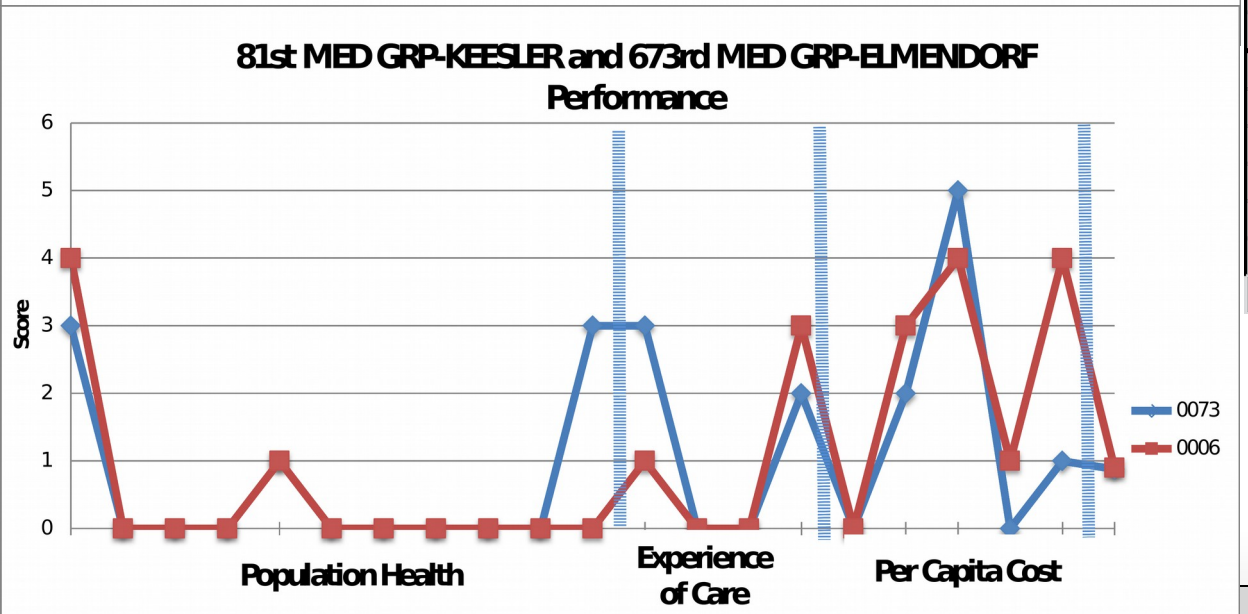
Army Site Performance Slide 2



Population Health – 20%	%Vst w/ PCM
	3rd Avail Acute
	3rd Avail Routine
	Diabetes A1c Screen
	Diabetes LDL <100 MG/dL
	Diabetes A1c >9
	Cholesterol Mgmt LDL Screen
	Cholesterol Mgmt LDL Control
	MH Follow-up 7 days
	MH Follow-up 30 days
Experience of Care – 20%	Mammogram Screening
	Colorectal Screening
	Cervical Screening
	Well Child Visits
Per Capita Cost – 30%	PMPM
	ER Vst/100
	Cost per MS-RWP
	Cost per Super RVU
	MS-RWP / 1000 Eq Lv
	SRVU / Eq Lv
Total Score	

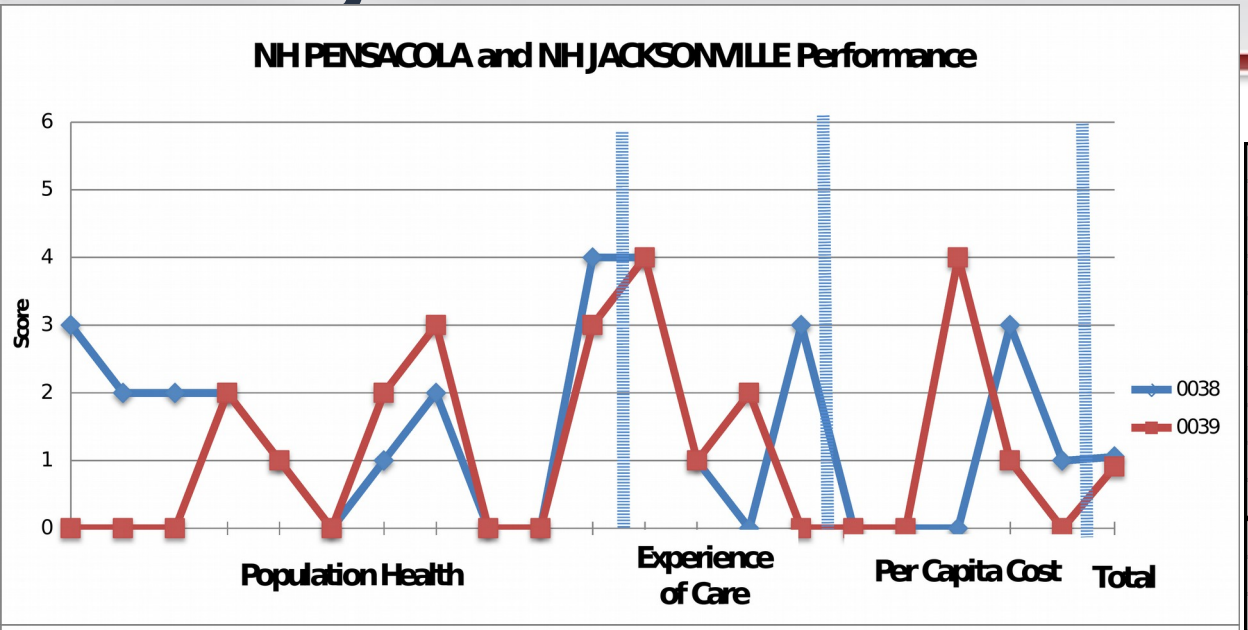
Air Force Site Performance

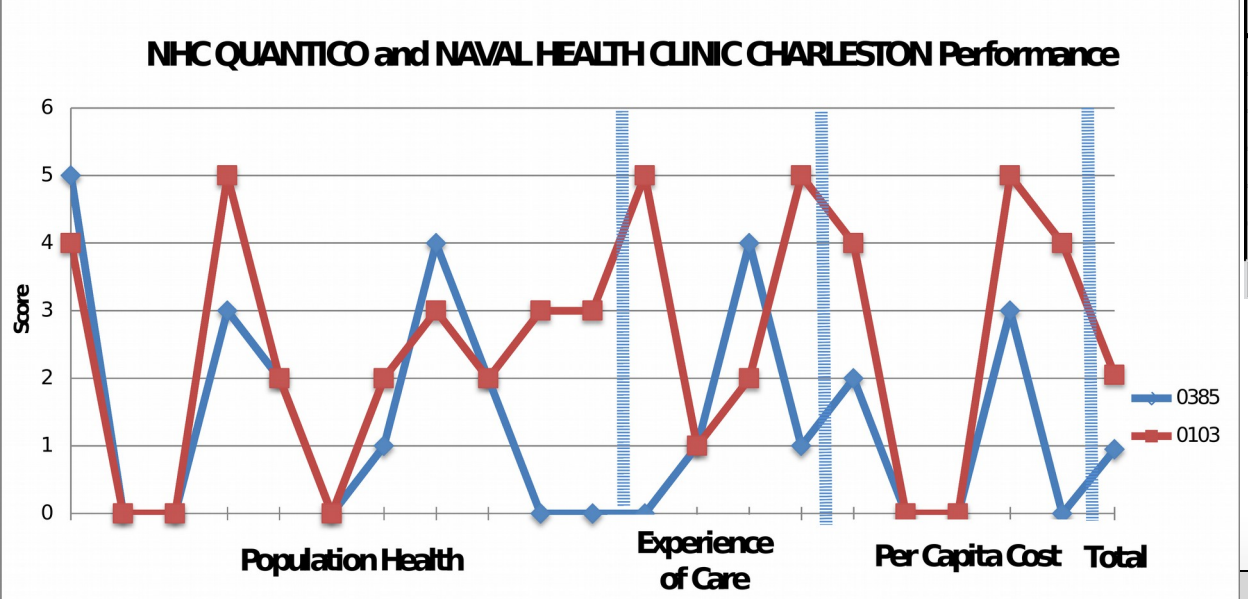




Population Health – 20%	%Vst w/ PCM
	3rd Avail Acute
	3rd Avail Routine
	Diabetes A1c Screen
	Diabetes LDL <100 MG/dL
	Diabetes A1c >9
	Cholesterol Mgmt LDL Screen
	Cholesterol Mgmt LDL Control
	MH Follow-up 7 days
	MH Follow-up 30 days
Experience of Care – 20%	Mammogram Screening
	Colorectal Screening
	Cervical Screening
	Well Child Visits
Per Capita Cost – 30%	PMPM
	ER Vst/100
	Cost per MS-RWP
	Cost per Super RVU
	MS-RWP / 1000 Eq Lv
	SRVU / Eq Lv
Total Score	

Navy Site Performance





Population Health – 20%	%Vst w/ PCM
	3rd Avail Acute
	3rd Avail Routine
	Diabetes A1c Screen
	Diabetes LDL <100 MG/dL
	Diabetes A1c >9
	Cholesterol Mgmt LDL Screen
	Cholesterol Mgmt LDL Control
	MH Follow-up 7 days
	MH Follow-up 30 days
Experience of Care – 20%	Mammogram Screening
	Colorectal Screening
	Cervical Screening
	Well Child Visits
Per Capita Cost – 30%	PMPM
	ER Vst/100
	Cost per MS-RWP
	Cost per Super RVU
	MS-RWP / 1000 Eq Lv
	SRVU / Eq Lv
Total Score	